

Fax Transmittal Sheet

Nevada Medicaid and Nevada Check Up – Rehabilitation FA-11A Authorization Request

To: Nevada Medicaid MH Rehab Program

Fax Number: (866) 480-9903

Phone Number: (800) 525-2395

From:

Fax Number:

Phone Number:

Date:

Number of Pages:
(including this cover page)

Urgent

For Approval

Please Comment

Please Reply

Comments

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Nevada Medicaid and Nevada Check Up
Behavioral Health Authorization Request
(For provider types 14, 26 and 82)

Fax request to: (866) 480-9903

Questions? Call: (800) 525-2395

Request Date:		Recipient Name:	
REQUEST TYPE: <input type="checkbox"/> Initial Prior Authorization – Start date of services: _____			
<input type="checkbox"/> Concurrent Authorization <input type="checkbox"/> Unscheduled Revision			
<input type="checkbox"/> Reconsideration <input type="checkbox"/> Retrospective Authorization – Date of Eligibility Decision: _____			
I. COORDINATING QMHP			
Name:		Credentials:	
NPI:	Phone:	Fax:	
Address (City, State, Zip):			
II. REQUESTING PROVIDER			
Name:		Credentials:	
NPI:	Phone:	Fax:	
Requesting provider's group NPI:			
III. RECIPIENT			
Name:		DOB:	
Recipient Medicaid ID:		Age:	
Recipient's Living Arrangements (e.g., group home, foster home, parents):			
Is the recipient in State custody? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date recipient went into State custody:	
IV. RESPONSIBLE PARTY			
Organization/Legally Responsible Adult Name:		Phone:	
Address (City, State, Zip):			
Relationship to Recipient:			
V. ICD-10 DIAGNOSIS			
<i>(If using DC:0-3, use the appropriate crosswalk and enter the appropriate ICD-10 diagnosis code and disorder)</i>			
Primary Code:	Disorder:		
Secondary Code:	Disorder:		
Tertiary Code:	Disorder:		
Clinical Assessor name and Credentials:			Date:
VI. ASSESSMENT SCORE			
<input type="checkbox"/> CASII	Score:	Level:	Date:
<input type="checkbox"/> LOCUS	Score:	Level:	Date:
<input type="checkbox"/> ECSII or Other Assessment (specify):	Score:	Level:	Date:
Clinical Assessor Name:		Credentials:	

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VII. SYMPTOMS AND SIGNIFICANT LIFE EVENTS *(List symptoms and/or significant life events that relate to the recipient's Axis I diagnosis and/or that brought the recipient to treatment, e.g., pertinent family information, developmental history, medical issues, sexual history, substance abuse and legal history.)*

VIII. TREATMENT PLAN AND RATIONALE *(Identify for each problem/behavior, long and short term goals, strength and psychosocial support progress or regression during the last authorized period.)*

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IX. CURRENT MEDICATION(S) *(List current medications/dosage. Attach additional sheets if needed to fully document all medications.)*

Medication Name	Dosage/Frequency
1.	
2.	
3.	
4.	
5.	
6.	

X. PREVIOUS AND CURRENT TREATMENT *(Describe previous treatment for psychiatric and pertinent medical conditions.)*

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XI. REQUESTED AND APPROVED TREATMENT *The requester will be deemed the point of contact for this authorization request and is responsible for dissemination of all information regarding this request.*

Recipient Name:		Recipient ID:
Requester Name:		
Requester Fax:	Requester's Group NPI (must be Medicaid-enrolled provider group):	
Servicing Provider Name:		Servicing Provider Fax:
Servicing Provider Name:		Servicing Provider Fax:
Servicing Provider Name:		Servicing Provider Fax:
Servicing Provider Name:		Servicing Provider Fax:

"Req." is an abbreviation for Requested Service. Enter your requested services on this row. "Units per day" multiplied by "Days per Week" multiplied by the total number of weeks in the entire date span equals "Total Units." "App." is an abbreviation for Approved Service. Nevada Medicaid will enter approved service information on this line after receiving your completed request.

Code	Modifier	Servicing Provider Name	NPI/API		Start Date and End Date	Units per Day	Days per Week	Total Units	Authorization Number
1				Req.					
				App.					
2				Req.					
				App.					
3				Req.					
				App.					
4				Req.					
				App.					
5				Req.					
				App.					
6				Req.					
				App.					

Requester's Signature:								Date:	
Date Received:		Reviewer Initials:			Date Deferred to MD:			Date of Determination:	

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XII. SERVICE LIMITS

Are you requesting units above the established limits for the recipient's level of care? Yes* No
***If yes, complete the two questions that follow.** Such services must be prescribed on the recipient's Rehabilitation Plan and can only be prior authorized for up to 30 days.

Provide a one-year history of the recipient's inpatient psychiatric admissions and residential treatment:

Provide a 90-day history of the recipient's most recent outpatient psychiatric services:

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.